TRIAL

Queensland Government

Central Queensland Hospital and Health Service

Early Pregnancy Assessment Service (EPAS) REFERRAL

Facility / Unit: Rockhampton Hospital

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date of referral: .....

GP / Consultant Name: ..... Provider No: .....

GP Practice / Department: .....

Referral to: .....

Regular periods: ☐ No ☐ Yes LNMP: ..... Gestation: ...../ 40

Pregnancy confirmed by: ☐ Urine test ☐ BhCG ☐ USS

☐ Blood group + Antibodies and BhCG collected ☐ Blood group: .....

☐ USS attended/booked Result : .....

.....

Criteria

- ☐ Less than 20 weeks gestation
- ☐ Clinically stable with:
  - ☐ Threatened miscarriage
  - ☐ Ectopic pregnancy
  - ☐ Pregnancy of unknown location (PUL)
  - ☐ Non-viable pregnancy/Fetal demise -USS
  - ☐ Missed miscarriage: .....
- ☐ Other: .....

Relevant history: G: ..... P: ..... M: ..... T: .....

- ☐ Previous STI / PID
- ☐ Previous pelvic surgery
- ☐ Endometrioses
- ☐ Contraceptive Use
- ☐ Smoking

Please send signed referrals to FAX: (07) 4920 6862

EPAS information given to patient: ☐ Yes ☐ No

For any further enquiries ring EPAS on (07) 49206438 or email EPAS.Rockhampton@health.qld.gov.au

Staff Name (print): ..... Designation: .....

Signature: ..... Date: .....

EPAS REFERRAL

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All clinical forms creation and amendments must be conducted through Health Information Unit

CQ893 v0.1-11/2021 *Printed Locally* *Trial Expiry: 24/02/2022*

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